The OAD Clinic

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We do not currently rate independent standalone substance misuse services.

We found the following issues that the service provider needs to improve:

- Clients were not supervised when commencing the use of prescribed medicines for detoxification after the initial dose.
- Clients did not all have comprehensive physical health assessments before or during their treatment.
- Staff did not regularly communicate with clients' GPs to ensure they were aware of the care and treatment the service provided.
- The service did not manage medicines safely. The system in place to manage prescription pads was not well organised.
- Random drug testing did not take place at appropriate intervals.
- Staff did not comprehensively assess the health and safety risks to clients, despite the service treating high-risk clients.
- Clients did not always receive regular reviews from an appropriately qualified professional.
- Clients did not have comprehensive care plans in place.

Summary of findings

- Comprehensive and robust policies and procedures were not fully in place to cover all aspects of the care of clients using a community substance misuse service.
- The service did not have appropriate governance systems in place that assessed and monitored the quality and safety of the service.
- Clients did not have access to a range of leaflets to inform them about the types of treatment that are available at the service and other support networks.

However, we also found the following areas of good practice:

- Staff discussed incidents and lessons learned. The service had an effective reporting system in place.
- Staff received regular clinical and managerial supervision with their line manager.
- The service reported medicine related incidents to NHS England and carried out medicine audits to ensure that clients were prescribed safe dosages of controlled medicines.
- The service provided online appointments and an evening clinic once a week for clients who worked or could not always attend the service.
- Staff ensured that they followed up clients who did not attend appointments or disengaged with the service.
- The service handled complaints appropriately.
- Clients we spoke with gave positive feedback about the service and staff. Clients felt their care and treatment met their needs.
- All staff attended a monthly-integrated governance meeting where staff discussed incidents, complex cases and good practice.

As a result of the safety concerns identified during the inspection, we proposed to impose a condition (Section 31 of the Health and Social Care Act 2008) on the provider unless the provider voluntarily stopped accepting new clients into the service. The provider agreed to not admit new clients into the service until improvements had taken place. We took this action as we believed people using this service might have been exposed to a serious risk of harm.

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Background to The OAD Clinic

The OAD Clinic is a community-based alcohol and drug detoxification service. The provider took over the service in July 2016. The service provides clinical treatment to clients based throughout the UK. The service offers online appointments to clients who cannot always attend the service. The service provides a range of treatments that include; opiate substitute prescribing, alcohol treatment programmes, Naltrexone implants as part of relapse prevention treatment, one-to-one support, online appointments, and counselling. The service also offers a pain clinic for clients who are addicted to medicines used for pain relief.

The service accepted the caseload from the previous provider and had a caseload of 250 clients at the time of inspection. The average caseload per substance misuse worker was 61 clients.

The majority of clients are self-funded but the service can accept referrals from the NHS.

The service has a registered manager in place and has been registered with the care quality commission (CQC) since July 2016. The service had not been inspected before. The service is registered by the CQC to provide treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures. The inspection team visited the service between 29 March and 31 March 2017.

Our inspection team

The team that inspected the service comprised of three CQC inspectors, a CQC inspection manager, a CQC pharmacy inspector, one specialist advisor who was a consultant psychiatrist with a background in substance misuse and an expert by experience. An expert by experience is a person who has personal experience of using, or supporting someone using, substance misuse services.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme to make sure health and care services in England meet the Health and Social Care Act 2008 (regulated activities) regulations 2014.

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about the location and gathered feedback from staff members in response to an email we asked the provider to send to them.

During the inspection visit, the inspection team:

Summary of this inspection

- visited the service, looked at the quality of the physical environment and observed how staff were caring for clients
- spoke with six clients
- spoke with the registered manager and the service manager
- spoke with three other staff members, including key workers and a doctor
- collected feedback using comment cards from five clients
- looked at 18 care and treatment records
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We collected feedback from clients and comment cards. Overall, clients we spoke with had a positive experience at the clinic. Clients told us that staff were approachable and professional. Clients felt safe and secure at the clinic and thought that the service supported clients to work as they offered an evening clinic. Clients told us that the service met their needs.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently rate standalone substance misuse services.

We found the following areas for improvement:

- The service's opioid detoxification treatment protocol did not include arrangements for clients to be supervised while taking their medicine after the initial 'test' dose. This meant that clients were at risk of overdose during the time they initially commenced their treatment.
- The service did not consistently liaise with clients' GPs regarding the treatment they provided. There was a risk that clients could be receiving more than one prescription (double scripting). It also meant the service may not be aware of the clients changing physical health needs.
- The service did not manage medicines safely. The service's system for producing and checking prescriptions was unsafe.There was a risk that clients could receive a prescription for the wrong medication or receive the prescription twice.
- The service did not appropriately assess and manage all the clients' individual risks. There were no management plans in place to support clients in a crisis.
- The service's training and development policy did not set out when staff were expected to attend refresher training. The policy did not clearly demonstrate the training expectations for agency and part-time staff.
- The service had not ensured that all medical devices were serviced regularly. The weighing scales had not been serviced, meaning they may not provide accurate readings.
- The service did not follow infection control principles. The provider did not record when clinical equipment was cleaned, therefore could not be assured that the equipment used on clients was clean.

We found the following areas of good practice:

- There was an effective system in place for staff to report and review incidents. Staff discussed incidents and their learnings from them.
- All staff had undergone appropriate recruitment checks including criminal record checks (DBS).
- The service reported medicine-related incidents to the Controlled Drugs Local Intelligence Network (CDLIN) at NHS England. This demonstrated that the service was open and honest about errors made in practice.

Summary of this inspection

Are services effective?

We do not currently rate standalone substance misuse services.

We found the following areas for improvement:

- Staff did not always carry out appropriate physical health assessments at the start of, and throughout, their treatment. Staff did not always explore clients' blood borne virus (BBV) status as part of the assessment. This increased the risk of clients having undetected physical health problems in the community.
- Staff did not carry out random drug screenings at regular intervals with clients. This increased the risk of clients using illicit drugs in addition to their prescribed medicines, as this would not be detected.
- The provider did not adhere to national guidance relating to the frequency of client reviews by an appropriately qualified professional. The service did not always review clients in line with their individual needs.
- Care plans were not always in place for clients who had specific needs. Care plans did not always reflect client preferences.
- Staff did not always record psychosocial interventions that clients received. The lack of documentation meant that it was unclear if clients had received psychosocial support in accordance with best practice guidance.
- Staff did not document when new staff members had completed an induction into the service.

However, we also found the following areas of good practice:

- Staff received regular clinical and managerial supervision with their line manager.
- Staff carried out regular prescribing audits to ensure that clients were prescribed safe dosages of medicines.

Are services caring?

We do not currently rate standalone substance misuse services.

We found the following areas of good practice:

- Clients gave positive feedback about the service and staff. Clients felt involved in their care and treatment.
- We observed staff being polite and caring towards clients.
- Clients were able to provide feedback to the service. The provider told us that they planned to start a client survey in 2017.

Are services responsive?

We do not currently rate standalone substance misuse services.

Summary of this inspection

We found the following areas of good practice:

- The service provided online appointments and an evening clinic once a week for clients who worked or could not attend the service.
- Staff followed up on clients who did not attend appointments or disengaged with the service. We found examples of joint working with other providers and community services to ensure clients' range of needs were supported.
- The service handled complaints appropriately.

However, we also found the following areas for improvement:

- Clients did not have access to a range of leaflets that they could take away with them. Leaflets were not available that informed clients about opening times, community groups such as alcoholics anonymous (AA), narcotics anonymous (NA) and education on substance misuse.

Are services well-led?

We do not currently rate standalone substance misuse services.

We found the following areas for improvement:

- The service did not have robust governance systems in place to assess and monitor the quality and safety of the service. The systems were ineffective, as they had not identified the concerns raised during the inspection.

However, we also found the following areas of good practice:

- All staff attended a monthly integrated governance meeting where staff discussed incidents and complex cases.
- The service had a comprehensive business contingency plan in place as well as a central risk register.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

Clients voluntarily approached the service for treatment and they were presumed to have the capacity to consent.

We saw evidence that clients consented to treatment and clients had a capacity assessment when required. All staff had attended mandatory Mental Capacity Act training in the past 12 months.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The service carried out appropriate fire safety checks, which included a fire safety risk assessment and regular fire drills.
- Domestic staff followed a cleaning schedule for communal areas, but this did not include clinical equipment such as the blood pressure machine. This meant that the service could not be assured that adequate measures were in place to prevent the spread of infections. The environment was clean and tidy.
- The service had a clinic room to store medicines and carry out minor surgical procedures for implants of a medicine called Naltrexone. There was an examination bed and appropriate hand washing facilities. The service had appropriate equipment in place to test for drugs and alcohol. Staff measured the fridge and room temperatures on a daily basis to ensure medicines were stored in line with manufacturing guidance. The service used disposable equipment for the Naltrexone implant. The equipment was in date.
- The service had an appropriate clinical waste management system in place to dispose of surgical waste. Staff were using clinical sharps bins correctly and ensured they were not overfilled.
- Staff had access to a range of clinical equipment such as a blood pressure machine and weighing scales. Most of this equipment was new. The weighing scales were old and had not been serviced, so may not provide accurate readings. The service manager told us that the service was going to implement a 'medical devices' list for the clinical equipment and would ensure the scales were added to this for a service.
- Staff were working in a safe environment. Following an incident of aggression from a client, the service had implemented the use of personal panic alarms. Staff also had access to telephones, which were available in all consultation rooms.

Safe staffing

- The service had a full-time service manager in place. There were three other full-time members of staff, which included; one full-time prescribing doctor who was also the medical director, an administrator and a substance misuse worker employed by an agency. The service also employed part-time staff, which included two substance misuse workers who were qualified psychotherapists and psychologists, a consultant anaesthetist and who carried out Naltrexone implants and a locum doctor. The service planned to directly employ the agency substance misuse worker on a permanent basis from May 2017. Since the service opened in July 2016, there had been a 50% turnover rate and no staff sickness.
- The service completed full recruitment checks for all staff. We reviewed six employment records and found that all staff had provided appropriate references and had undergone criminal background checks (DBS).
- Full-time staff and part-time substance misuse workers had completed mandatory training with an overall completion rate of 86%. A new administrator and an agency substance misuse worker had not yet completed all training and this was planned for April and May 2017. The service's training and development policy referred to permanent staff only and did not demonstrate the training expectations for part-time and agency staff. The policy did not outline how often staff were required to refresh their mandatory training.

Assessing and managing risk to clients and staff

Substance misuse/detoxification

- The service had created a comprehensive risk assessment and risk management plan called the 'risk and recovery plan'. The plan was introduced for all new clients coming in to treatment.
- The service had not ensured that the longer term clients' individual risk assessments and risk management plans effectively managed the risks identified. We looked at the records for 18 clients and found that five clients presented as a risk to themselves or others. However, the risk assessments did not accurately reflect the risk itself and how the service would manage the risk. For example, a client's risk assessment recorded that they were not at risk despite the client being Hepatitis C positive. There was no risk management plan in place to show how this would be managed alongside treatment at the service.
- Staff did not discuss risks regularly. Staff discussed some clients and their risks at the monthly team meeting. However, there was no other opportunity for staff to discuss high-risk clients more frequently.
- Staff did not complete crisis management plans with clients. In 18 records we looked at, none had a crisis plan in place. Without a clear plan, there was a risk that clients in crisis would not be fully supported.
- Staff did not always ensure that they had reported clients who had a driving licence when needed to the Driver and Vehicle Licencing Agency (DVLA). One client was recorded as holding a driving licence but staff had not recorded if they had considered if there was a need to report this. The service did not adhere to national guidance when the situation arose to report clients, which meant that the provider increased the risk of clients driving unsafely.
- Staff risk assessed clients who had children or were in contact with children, to ensure they were suitably safeguarded.
- Staff did not always ensure that client risk events and self-disclosures were reflected in the individual clients' risk assessment and risk management plans. One record showed that a client had been aggressive on a few occasions whilst at the clinic. Staff had written that there was insufficient time to update the care plan and risk assessment. There was no risk management plan in place to record how the client's aggression would be minimised and managed. In another record, a client had disclosed that they were 'using on top'. This meant that the client was using illicit drugs in addition to their prescribed medicines, which causes a risk of overdose. Staff had not clearly documented that the disclosure had prompted a review of risk for the client.
- Records showed staff did not always gain consent to contact individual GPs with clients or routinely communicate with clients' GPs about the treatment they provided. We found that in eight of the 18 records reviewed, staff had not obtained consent to contact clients' individual GPs or that the associated risks had been clearly explained to the clients. The prescribing doctor did not always follow the provider's own policy to inform GPs of changes in prescribing. There was a risk that clients could access another prescription from their GP and receive double the amount of medication. This could potentially lead to an overdose. The prescribing doctor continued to prescribe to clients despite knowing these risks. There was also a risk that clients may have developed physical health problem and the clinic staff would not be aware of this.
- Medicines management was not taking place safely. Staff did not record when and how medicines were destroyed. The service manager told us that expired ampoules of medicines were opened and poured down the sink. This was not safe practice and was against recommended guidance as it posed risks to the environment and increased the risk of medication diversion. The service did not document when they had taken medicines to the pharmacy for destruction. All staff had access to blank prescription pads, which was unsafe because prescription pads are controlled stationery items due to their high street value in the community. Staff did not accurately log prescription numbers in a chronological order and, on some occasions, records were not adequately completed. The service did not maintain accurate records of void prescriptions. This meant that when prescriptions were not to be used due to an error they were classed as 'void'. We found that a duplicate prescription that the provider believed was void was used to prescribe another client medication. The provider's management of prescriptions and prescription records increased the risk that clients may receive a prescription twice (double scripting), which leads to a risk of overdose. Following

the inspection, the provider sent us an action plan demonstrating how the service would address our concerns. The provider immediately implemented a prescription management policy for staff to refer to.

- The service performed 'tolerance testing' for clients who were prescribed methadone ampoules to inject. An experienced doctor directly supervised clients and monitored them for adverse side effects. Whilst the provider ensured that tests and observations were documented, the provider did not have this assessment procedure documented within a policy or protocol. This meant that this procedure was being carried out without any clear have a detrimental effect on clients' safety.
- The service did not supervise clients taking their medicine after the initial 'test' dose. National guidelines recommend that during the period of medicines optimisation patients should be directly supervised by a qualified clinician for a period of time (usually around 3 months) appropriate to their needs and risks. The prescribing doctor told us that the service did not carry out supervised consumption because of cost implications. The lack of policy and supervision of clients taking their prescribed medicines meant that clients were at risk of harm when they started their treatment.
- The service had a policy in place to respond to a medical emergency. The service manager and the prescribing doctor were trained in administering a medicine called Naloxone, used in the event of an opiate overdose. In the event of a medical emergency, staff called emergency services.
- Staff received safeguarding training for vulnerable adults and children at risk. The service manager was the safeguarding lead. The service had a safeguarding policy in place.

Track record on safety

- Since the service opened in July 2016, there had been two client deaths in the community. At the time of the inspection, one incident was still undergoing investigation. For one of the deaths, the provider had been asked to provide a report to the coroner. There was no evidence to indicate that these incidents were directly related to the care and treatment provided by the service.
- All staff attended the monthly-integrated governance team meetings. The meeting records demonstrated that senior staff shared updates about incidents and learning with other team members.

Reporting incidents and learning from when things go wrong

- The service had an effective incident reporting system in place. The service had an incident reporting policy in place, which outlined the incidents that required reporting. Staff reported incidents on a specific form and understood how to raise an incident. The service manager kept an incident-reporting log and reviewed all incidents. Incidents were discussed on a monthly basis at the team meeting. Following an incident of aggression, the senior staff had reviewed the safety measures in place in the clinic. This led to the service implementing personal panic alarms.
- The provider reported medicine incidents to the local controlled drugs accountable officer at NHS England. The accountable officer reviewed and assessed controlled drugs related incidents.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. The service's duty of candour policy and incident reporting policy outlined the duty of candour requirements and indicated their responsibility towards clients and their families. The policy included a list of agencies that should be informed if something went wrong. Staff we spoke with were able to give examples of when duty of candour would apply.

Are substance misuse/detoxification services effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- Whilst medical staff carried out initial assessments before clients started treatment, there were gaps in the physical health checks carried out on clients before and during treatment. The clinical records of nine clients

failed to demonstrate that assessments included the relevant physical health checks in line with National Institute for Health and Care Excellence (NICE) guidance. Three clients were prescribed Naltrexone, which is a medicine that can cause liver damage. None of these clients had a liver function test before or during treatment. The lack of blood monitoring before and during treatment meant that the prescribing doctor had not followed their own ' policy' and had not adhered to national guidelines when commencing this type of treatment. The lack of regular physical health checks and monitoring meant that clients were put at risk of harm to their health.

- Staff did not monitor the physical health of clients during their treatment, which could put clients at risk. One client treated by the previous provider was prescribed a high dose of methadone medication. High doses of methadone could potentially cause serious heart problems in some people. To minimise the risk, clients were expected to have a heart monitoring check (ECG) before and during treatment. However, the client had opted out of having ECGs with the previous provider and the current provider had not reviewed this. The client's record did not demonstrate they were having their physical health closely monitored.
- Staff did not always ensure that during treatment, clients completed random drug screenings at regular intervals. In seven out of 18 records, we found no record that the clients had a random drug test at regular intervals during treatment. This meant that the provider did not know whether clients were taking illicit drugs in addition to their prescribed medication, which could potentially result in overdose.
- Policies and protocols did not clearly demonstrate the specific assessments and screening clients needed before and during treatment. The policies lacked guidance on when random drug testing should take place and the specific physical health checks clients needed such as blood pressure and pulse. This meant that there was no clear guidance for staff to refer to.
- Doctors at the service were able to take bloods but mostly signposted clients to the local blood test service.
- An appropriately qualified care professional (usually a doctor or nurse) did not review clients at clearly defined intervals in line with their individual needs. The prescribing doctor told us that a doctor should review each client at least every six months. This did not follow best practice guidance. National guidelines on clinical management of drug use and dependence state longer-term prescribing should be reviewed at regular intervals. The lack of regular reviews meant that the service could not be assured that the treatment all clients received was safe, effective and met their needs.
- The provider did not always ensure that clients' blood borne virus (BBV) status was assessed. In four out of 18 records, staff had not explored whether the clients had been formally checked in the past. This meant that clients may be at risk and not aware of the treatments available to them.
- Whilst most clients had care plans in place. We found that two longer term clients that had transferred from the previous provider did not have care plans in place that reflected their preferences and effectively met their needs. The clinical records demonstrated that staff had assessed the clients individual needs but there was no care plan in place to demonstrate how the client would be supported or monitored. For example, the client had recognised their triggers, which caused relapse. The clinical record did not demonstrate that the service had explored strategies to address this need. This did not ensure that the client would receive effective care that met their needs.
- Staff stored information securely in paper files. The files were stored in a locked cupboard in the administration office.
- The service ensured that clients had access to a face-to-face meeting before they exited treatment. The meeting gave staff an opportunity to engage with the client and provide support. For clients moving to another provider, the service sent a discharge letter to ensure that important information was handed over to the next service.

Best practice in treatment and care

- The service had an ' policy' that provided clear guidance for the Naltrexone implant procedure which was carried out by a trained Consultant Anaesthetist. The policy included a clear exclusion criterion for clients who would not be suitable for the implant. The policy provided guidance for staff prior to the procedure, details of each stage of the procedure and after the

procedure. Clients who had been treated with a Naltrexone implant were given a comprehensive information document to take away with them including an information card to inform medical professionals in the event of an emergency.

- The provider carried out regular prescribing audits to review and assess that the prescribing was safe and in line with national guidance. In August 2016, the service carried out a medication audit to review the prescribing regimes for all clients who were prescribed controlled medications. The audit revealed that the previous provider had prescribed high dosages of controlled medications to some clients. The prescribing doctor told us that they reviewed all of these clients as a priority in order to begin medication reduction regimes. In January 2017, the service manager carried out an audit for clients who had been prescribed long-term amphetamines. The prescribing doctor subsequently reviewed these clients. Medication reduction plans were in place for clients.
- Whilst the service employed a counselling psychologist and an addictions counsellor to carry out psychosocial interventions, they did not always ensure that staff clearly documented psychosocial support. We reviewed 18 clinical records and found that in one record there was no evidence to demonstrate that any psychosocial interventions had taken place during treatment at the service. In another record, the last recorded psychosocial intervention was in September 2016. The lack of adequate recording of interventions meant that it was unclear as to whether clients received the appropriate psychosocial support in line with best practice guidance.

Skilled staff to deliver care

- The service employed a range of professionals including a substance misuse worker, a psychologist, a counsellor, a pain specialist, and a psychiatrist.
- Whilst the service provided staff with an induction, this was not formally recorded. The service had a staff and volunteer pre-employment policy in place, which clearly showed what new staff members could expect. The new staff confirmed that they had completed an induction. The policy stated that new staff would receive an induction pack; however, the service manager told us that this had not yet been implemented.
- Staff received regular monthly to six-weekly supervision. All staff received clinical and management supervision, which was in line with best practice guidance. The service had a supervision and appraisal policy in place.
- The service opened in July 2016 and had not yet carried out any annual appraisals.
- Staff had access to specialist training focused on supporting clients with alcohol and drug problems. The service provided mental health related training such as attention deficit hyperactivity disorder and suicide prevention. Staff attended training that was relevant to their role.

Multidisciplinary and inter-agency team work

- The service held monthly team meetings. The meetings included discussions about complex clients, safeguarding and risk concerns and general business matters. The meetings were well attended by all staff.
- The service had worked with community services when clients had disengaged with the service. We saw evidence that the staff had worked jointly with a community mental health team (CMHT) and had attended a case conference to ensure the service was involved with the support plan for the client.

Good practice in applying the MCA

- Eighty percent of permanent staff had received Mental Capacity Act training in the past 12 months. One agency member of staff was due to complete their training in May 2017.
- Clients voluntarily approached the service for treatment and they were presumed to have the capacity to consent. We saw evidence that clients gave consent prior to treatment commencing. We saw evidence that consent to treatment was documented in the clinical records.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- During the inspection, we observed staff to be polite and caring towards clients.

Substance misuse/detoxification

- Feedback from five clients and four comment cards was very positive. Clients told us that they felt safe and secure and that staff were approachable. We heard positive comments such as 'the clinic is a lifesaver', 'I have been able to have a steady job', and 'it gives me the ability to live a normal life'. Other clients felt that the service supported them to work because the service provided an evening clinic.

The involvement of clients in the care they receive

- Clients told us that they felt involved in their care and treatment.
- Clients had access to a suggestions box, which was located in the service waiting room. The service planned to start a client survey in 2017.

Are substance misuse/detoxification services responsive to people's needs? (for example, to feedback?)

Access and discharge

- Clients were able to self-refer in to the clinic or be referred by other private providers and the NHS. At the time of the inspection, the service did not routinely collect data about admissions into treatment, discharges, clients who did not attend appointments (DNA) and clients who suddenly exited treatment. The service was planning to monitor these once the new electronic care record system had been fully implemented.
- The service provided a weekly evening clinic and offered online appointments to clients who could not always attend the service or worked during the day.
- At the time of the inspection the service had a draft missed appointments and re-engagement procedure in place, which had not yet been signed off. The policy guided staff in how to respond if a client disengaged with the service. In two records, we found that staff followed the policy and had attempted to engage with the client and community services.

The facilities promote recovery, comfort, dignity and confidentiality

- The service offered a variety of consultation rooms as well as a medical surgery room. The surgery had an examination bed and other clinical equipment. Clients had access to a water cooler that was located in the waiting room.

Meeting the needs of all clients

- Clients did not have access to a range of leaflets to inform them about the types of treatment that were available at the service and other support networks. Leaflets were not available that informed clients about opening times, community groups such as alcoholics anonymous, narcotics anonymous, and education on substance misuse.
- The service accepted clients who were from different backgrounds and who lived within the UK. The service also provided treatment to clients who travelled from other countries and were based in the UK.
- The service did not follow their own equality and diversity policy when providing care and treatment to clients with protected characteristics. Individual client assessments did not record this information.
- The layout of the building meant that a person that required assisted access for mobility needs could not access the clinic. Instead, the service had an informal arrangement in place with the GP practice next door, whereby a client could be seen on the ground floor.

Listening to and learning from concerns and complaints

- A comments and suggestions box as well as complaints forms were available in the clinic waiting room. Clients understood how to make a complaint.
- The service handled and managed complaints appropriately. Staff had kept a clear log of the two complaints that had been received since the service opened in July 2016. The complaint records clearly demonstrated that the provider had formally acknowledged the complaints, met with the two complainants and had resolved the issues. The complaints had been shared with staff in the monthly staff meeting for future learning and improvement.
- Staff understood how to raise concerns and felt confident to give feedback to the service manager and medical director.

Substance misuse/detoxification

Are substance misuse/detoxification services well-led?

Vision and values

- Staff understood the aim of the service. Staff we spoke with were committed to providing a safe and professional service that helped clients to recover and abstain from drugs and alcohol. Senior staff acknowledged that the service required further improvement and were committed to achieving this.

Good governance

- Whilst the service had improved by implementing some new policies and procedures, however the systems in place were not effectively monitoring the quality and safety of the service. The systems put in place since transfer of ownership did not identify the concerns that were raised during the inspection.
- For example, the service did not have a system in place for managing prescriptions safely and supervising clients taking their medicines at the start of their treatment and on an ongoing basis. The systems and There was no system to ensure that clients' GPs were contacted to ensure that clients' treatment was safe and effective. The service did not have a mechanism in place for consistently identifying and managing individual client risks. Staff did not keep adequate records of which clients had been reviewed and which clients were yet to be reviewed. Overall, the service did not have mechanisms in place to monitor and improve the quality and safety of the services provided. This meant that the service could not monitor and mitigate the risks relating to the health, safety and welfare of clients and others at risk.
- Some policies and procedures needed further work to ensure they covered all aspects of the work of the clinic and reflected good practice guidance.
- The service had systems in place to monitor and respond to incidents and safeguarding concerns. The service had a monthly integrated governance team meeting which was well attended by all staff. The meeting meetings demonstrated that staff discussed learning from incidents and complex cases.
- The service submitted statutory notifications to the care quality commission (CQC) as required.
- The service did not yet collect data about their performance and outcomes for clients using the service. However, since the service took over from the previous provider in July 2016, staff carried out audits to review the caseload and prescribing regimes. This was to ensure that clients were being prescribed safe dosages of medicine.
- The service had a comprehensive risk register in place. The register included risks to the organisation, staff and clients.
- A business contingency plan was in place, which was used as a guide for the service if there was a significant event that affected its running. The plans included scenarios such as the shortage of staff, issues with IT systems and problems with the premises. The plan included a recovery timeframe for each scenario.

Leadership, morale and staff engagement

- Morale had improved at the service and staff felt the team worked well together. Staff felt that the medical director was motivating in their approach.
- Staff we spoke with felt that the team recognised that there was still areas of practice that could be improved and were able to raise this with senior staff. We saw evidence of this in the team meeting minutes.

Commitment to quality improvement and innovation

- The service's business plan demonstrated the service's aim to develop joint working with educational institutions. The medical director of the service was an honourable university professor.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the service has a policy and system in place for supervising clients taking their medicine after the initial test dose.
- The provider must ensure that clients are regularly drug screened during treatment in accordance with best practice guidance.
- The provider must ensure that there is a system in place to consistently liaise with clients' GPs to inform them of the treatment the service is providing.
- The provider must ensure that the service comprehensively assesses and monitors clients' physical health prior to and during treatment. This includes assessing clients' blood borne virus (BBV) status and carrying out relevant blood tests.
- The provider must ensure that clients are always comprehensively risk and needs assessed. This includes risk management plans and crisis plans put in place prior to starting treatment.
- The provider must ensure that there are systems in place to manage medicines safely. This includes ensuring prescriptions pads are secure and prescription records are accurately completed and maintained.
- The provider must ensure that a qualified clinician regularly reviews clients, in line with best practice guidance.
- The provider must ensure they have comprehensive policies and procedures in place to meet the needs of clients using a community substance misuse service.
- The provider must ensure that there are governance systems in place to assess, monitor, and improve the quality and safety of the service.

Action the provider SHOULD take to improve

- The provider should ensure all clients have a comprehensive care plan in place.
- The provider should ensure that psychosocial interventions are carried out with clients and these are clearly recorded in the clinical records.
- The provider should ensure that staff follow infection control principles by recording when clinical equipment is cleaned.
- The provider should ensure that clinical equipment is regularly serviced, including the weighing scales.
- The provider should ensure that the provider's training and development policy clearly demonstrates the training expectations for all staff that work at the service.
- The provider should ensure that staff record that they have completed an initial work induction.
- The provider should ensure that clients have access to a range of leaflets to inform them about the types of treatment that are available at the service and other support networks.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Clients receiving maintenance treatment during detoxification were not being supervised taking their medication when they initially commenced treatment. Clients risks were not being assessed and sufficiently monitored. Known risks were not being reported, to other key professionals and other bodies. Medicines were not being managed safely in the service. Clients were not receiving physical health assessments before and during treatment. Regular reviews by an appropriately qualified professional were not always taking place. Clients were not regularly drug screened during treatment in accordance with best practice guidance. Contact with GPs was not taking place as required. This was breach of regulation 12(1)(2)(a)(b)(g)(i).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes were not established and operated effectively to ensure compliance.

This section is primarily information for the provider

Enforcement actions

The provider was not assessing, monitoring and improving the quality and safety of the service.

Policies and procedures needed further work to ensure they reflected best practice and covered all operational aspects of the clinics work.

The frequency of medical reviews and outstanding clients to be reviewed had not been recorded.

This was a breach of regulation 17(1)(2)(a)(b).